Moving from Report Room to the Bedside: Implementation of Educational Bundle to Change Acute Care Nursing Handoff Practice

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**Purpose:** To implement a hospital-wide educational intervention to standardize the acute care nursing handoff process, including bedside report and safety checks.

**Synthesis of evidence:** An analysis of peer reviewed research articles regarding nurse-to-nurse bedside report revealed that improvement in patient safety is the most frequently cited reason to implement bedside report. Bedside report and safety checks have been shown to reduce the incidence of medication errors, skin tears and falls. Furthermore, it allows for effective communication, active engagement and patient participation, while also promoting nursing accountability and teamwork. One of the biggest limitations of nurse-to-nurse bedside report is sustain hospital wide change and establishing report protocols.

**Proposed change in practice:** The UWMC handoff committee created a 5-minute standardized report process starting with bedside safety checks (including specific nursing roles verifying patient identifiers, code status, allergies, connected infusions, treatments, and safety interventions), followed by a streamlined report at the bedside including patient and family input.

**Implementing Strategies:** UWMC utilized a Plan, Do, Check, Act method to implement bedside report and safety checks. An initial survey was administered to all nursing staff to determine current report practices. A group of nurse champions were identified and asked to participate in a bedside report workshop. The workshop included a review of the literature, patient safety events, and initial survey results. Patient advisors were invited to share their experience and concerns with the inconsistencies in the current nursing report process. The nurse champions then designed a new process for report, as well as an education plan. After the workshop, the nursing champions trialed the new report process and gave recommendations for changes. These recommendations were incorporated into the final process and subsequent staff education. The 2 hour nursing class included a didactic section (video, demonstration, review of process) with hands on simulation experience and competency assessment.

**Evaluation:** After implementation, real time observations of nursing handoff and competency validations were completed, along with leader rounding on patients and anonymous staff surveys. In the post implementation surveys (n= 301), approximately 55% of staff endorsed following the new bedside safety checks and hand off all the time and 90% of staff reported some or all of the time. Patients reported similar findings with 66% of patients saying bedside report was happening all of the time, and 84% reporting most or all of the time. Finally, patient safety reports were also monitored post-implementation. There was an increase in the reporting of errors being caught during
safety checks.

**Conclusions:** We determined that the educational interventions did effect change in the nursing handoff process. Continued work is ongoing around sustaining our new process of bedside safety checks and shift report and monitoring of PSN events around hand off.

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